STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

GEORGE DEUKMEJIAN, *Governor*

DEPARTMENT OF HEALTH SERVICES
4/744 P STREET
SACRAMENTO, CA 95814

December 22, 1983

To: All County Welfare Directors

Letter No. 83-82

REVISED STATEMENT OF FACTS FOR MEDI-CAL (MC 210)

The purpose of this letter is to:

1. Provide you with a sample copy of the revised Statement of Facts for Medi-Cal (MC 210) together with a description of the changes.

2. Request your comments or suggestions for future revisions.

Revised MC 210

The MC 210 has been revised to reflect program changes and to provide for documentation of mandated verifications. The current production order has been limited so that we will have the flexibility to make future changes more quickly. Because of the cost, however, current supplies of the MC 210 must be exhausted before the new revision will be available.

This revision to the MC 210 currently is being translated into Spanish. Once this process is complete, the revised Spanish version (MC 210 SP) will be printed. Because of the lead time required, it will be some months before this version will be available.

County Comments

Those questions on the MC 210 designed to identify connection to the labor force and primary wage earner were adopted from AFDC's Statement of Facts Supporting Eligibility for Assistance (CA 2). We wish to know whether these and other changes have made the form more useful in gathering the information necessary to determine Medi-Cal eligibility and share of cost. We would appreciate your written comments and suggestions on how this form can be improved in the future.

Sincerely,

ORIGINAL SIGNED BY

Caroline Cabias, Chief
Eligibility Branch

Attachments

cc: Medi-Cal Liaisons
Medi-Cal Program Consultants

Attachment I

# STATEMENT OF FACTS FOR MEDI-CAL

PLEASE USE INK

**INSTRUCTIONS:**

Your eligibility will be decided on the information you give on this form. Be sure to read and answer every item. If you need extra space for any item, see page 9.
If you are completing this form on someone else's behalf, the terms "applicant" and "you" apply to the person you are applying for.
"Family member" means applicant, spouse, applicant's or spouse's children under 21.

1. Applicant's name (print) First Middle Last

2. Home Address Number Street City Zip Code

Mailing address (if different from above)

Home Phone Work phone Message phone Person with whom to leave message

**COUNTY USE ONLY**

Case name:

State No.:

App./redetermination date:

Verification of identity

Date EW

Verification of SS No.

1. Date EW
2.
3.
4.
5.
6.

Tax Record Verification

## 3. FAMILY MEMBERS

3A. List yourself and your spouse if he/she is in the home or Medi-Cal is being requested in his/her behalf.

| Name ((First, middle, last)) / Social Security (SS) No. | Sex | Birthdate (Mo/Day/Yr) / Birthplace | Marital Status: Single | Married | Divorced | Separated | Widowed | Living With Applicant: Yes | No | Medi-Cal Requested: Yes | No |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. Applicant / SS No. | | / / | | | | Date | | | | | |
| 2. Spouse / SS No. | | / / | | | | Date | | | | | |

3B. List all your and your spouse's unmarried children under 21 (be sure to list unborn children). Also, include any children out of the home for whom you are requesting Medi-Cal or whom you claim as a deduction for income tax purposes.

| | Sex | | In School: Yes | No | PARENTS 1) Father's Name 2) Mother's Name | Parent Is: (✓ if applies) Deceased | Absent | Incapacitated | Unemployed | Child Living With Applicant: Yes | No | Medi-Cal Req. for Child: Yes | No |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. / SS No. | | / / Place | | | (1) (2) | | | | | | | | |
| 2. / SS No. | | / / Place | | | (1) (2) | | | | | | | | |
| 3. / SS No. | | / / Place | | | (1) (2) | | | | | | | | |
| 4. / SS No. | | / / Place | | | (1) (2) | | | | | | | | |
| 5. / SS No. | | / / Place | | | (1) (2) | | | | | | | | |
| 6. / SS No. | | / / Place | | | (1) (2) | | | | | | | | |

3C. Did you or any family member use a different name than the one listed above when each of you applied for your Social Security number? Yes ☐ No ☐ If yes, list names.

3D. List the names and addresses of all persons listed in 3A or 3B if they are not living in your home.

| Name | Address |
|---|---|
| | |
| | |

4. Is there anyone other than you or your immediate family members living with you, such as roommate, housemate, or relative? Yes ☐ No ☐ If yes:

| Name | Relationship |
|---|---|
| | |
| | |

5A. Are you or any family member requesting Medi-Cal living or currently staying outside California?
Yes ☐ No ☐ If yes: Date left California ______________ Date expected to return ______________
Reason for absence:

B. Do you or any family member have a home outside California? Yes ☐ No ☐
If yes, are you or any family member working or looking for work in California? Yes ☐ No ☐
If no, explain why you are in California.

6. ARE ANY OF THE PERSONS LISTED IN 3A OR 3B ALIENS? Yes ☐ No ☐
If YES, complete:

| Name of Alien | Alien Registration Number |
|---|---|
| | |
| | |
| | |

7. Have you or any family member ever applied for or received in California or any other state:
AFDC Cash Assistance Yes ☐ No ☐ Medi-Cal Yes ☐ No ☐ Food Stamps Yes ☐ No ☐
SSI/SSP Gold Check Yes ☐ No ☐ Other Welfare Benefits Yes ☐ No ☐
If you answered yes on any item, complete the following:

| Name of Person(s) Who Applied For or Received Aid | Type of Aid | Date of App. (Mo/Day/Yr) | Place of App. | Date Last Received (if no longer receiving) (Mo/Day/Yr) | Reason For Discontinuance |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

8. If you or any family member were *not* receiving Medi-Cal in the last three months, did you or those family members receive any medical care? Yes ☐ No ☐ If yes:

| Name of Person Receiving Medical Care | Month(s) of Care | Payments Made For Care | | Do You Wish Medi-Cal For Those Months | |
|---|---|---|---|---|---|
| | | Yes | No | Yes | No |
| | | | | | |
| | | | | | |

9A. Are you or any family member requesting Medi-Cal:
65 or over? Yes ☐ No ☐ If yes, name(s) ______________________________
Blind? Yes ☐ No ☐ If yes, name(s) ______________________________

B. Do you or any family member have a physical or emotional problem which makes it difficult to work or take care of your needs? Yes ☐ No ☐ If yes:

| Family Member(s) | Type of Problem(s) | Beginning Date of Problem(s) |
|---|---|---|
| | | |
| | | |

C. If the problem described in 9B was caused by an injury or accident, are you seeking compensation through an insurance settlement or lawsuit? Yes ☐ No ☐

**COUNTY USE ONLY**

Where required, date CA 6 signed.

- Receiving or ap for cash grant or -Cal around August 1972? If yes, check for 20% SS increase eligibility.
- Four-month continuing eligibility?
- SGA disabled?
- Title II disregard?
- 30 + 1/3 earnings exemption?

Retroactive application

Retro only ☐
Retro and cont. ☐

☐ Verification of disability/blindness (list)

Date Verified EW

☐ Disability ref

Date Sent

☐ Referral to Medi-Cal recovery

... the following information about your living arrangements:

☐ Rent a room, apartment, house, or trailer $__________ Rent
☐ Pay for room and board $__________ Room and board
☐ Work in exchange for room and board
☐ Receive free room
☐ Receive free room and board
☐ Live in a board and care facility
☐ Live in a nursing home or hospital
Date entered __________ Date expected to return home __________
☐ Live in and own/buying a trailer, mobile home, boat, or motor vehicle which is *not* taxed as real property by the county.
Description: __________
Estimated value $__________ Amount owed $__________ Monthly payment $__________
☐ Live in and own/buying a home or a trailer or mobile home which is taxed as real property by the county.
Assessed value $__________ (from tax statement) Amount owed $__________ Monthly payment $__________
Land home is located on includes more than one parcel. Yes ☐ No ☐ If yes, complete 11.
Land home is located on includes more than one acre. Yes ☐ No ☐ If yes, complete 11.
☐ Other living arrangements. Describe:

11. Do you or any member of your family own real property which you do not now live in (for example, land or buildings) or a trailer or mobile home which is taxed as real property by the county and which you do not now live in? Yes ☐ No ☐ If yes:

Description: __________

Address: __________

Owner: __________ Used in part as a home? Yes ☐ No ☐

Full value (from tax statement $__________ Amount owed $__________ Rent collected each month $__________
Expenses on property:
Interest $______ Yearly ☐ Monthly ☐ Insurance $______ Yearly ☐ Monthly ☐
Taxes and Assessments $______ Yearly ☐ Monthly ☐ Upkeep and Repairs $______ Yearly ☐ Monthly ☐
Utilities $______ Yearly ☐ Monthly ☐

12. Do you or any family member have a life estate (right to the use of) in any property? Yes ☐ No ☐
If yes, describe:

13. Do you or any family member own a motor vehicle (including cars, trucks, motorcycles, etc.)?
Yes ☐ No ☐ If yes, list:

| Make and Model | Year | Class (From Registration) | Owner | Amount Owed | Used for Transportation | |
|---|---|---|---|---|---|---|
| | | | | | Yes | No |
| | | | | $ | | |
| | | | | $ | | |
| | | | | $ | | |
| | | | | $ | | |
| | | | | $ | | |

14. Do you or any family member own boats, campers (do not include trucks), motor homes, mobile homes, or trailers which are not used as a home and are not taxed as real property by the county?
Yes ☐ No ☐ If yes, list:

| Description | Year | Class (If Registered) | Owner | Purchase Price | Amount Owed | Only Means of Transportation | |
|---|---|---|---|---|---|---|---|
| | | | | | | Yes | No |
| | | | | $ | $ | | |
| | | | | $ | $ | | |
| | | | | $ | $ | | |
| | | | | $ | $ | | |

NOTE: If you think the value the Department of Motor Vehicles will give the items listed in 13—14 will be too high, you may provide three appraisals of the actual value and the average will be used.

COUNTY USE ONLY

Verification that will return home in six months
Yes ☐ No ☐

Verification of property

Date Verified EW

Verification of "good cause" for unutilized property

Date Verified EW

Verification of income and expenses (list)

Date Verified EW

☐ Revocable
☐ Irrevocable

Verification of nonexempt vehicles

Date Verified EW

Verification of personal property

Date Verified EW

15. DO YOU OR YOUR FAMILY HAVE ANY OF THE RESOURCES LISTED BELOW?
Check each item. If YES, explain below.

| | YES | NO |
|---|---|---|
| A. Checks (at home or elsewhere) | ☐ | ☐ |
| B. Cash (on hand or elsewhere) | ☐ | ☐ |
| C. Checking account | ☐ | ☐ |
| D. Savings account | ☐ | ☐ |
| E. Credit union account | ☐ | ☐ |
| F. Certificates of deposit | ☐ | ☐ |
| G. Treasury bills | ☐ | ☐ |
| H. Money market funds | ☐ | ☐ |
| I. Notes, mortgages, trust deeds, sales contracts | ☐ | ☐ |
| J. Trust fund | ☐ | ☐ |
| K. Stocks, bonds, or certificates | ☐ | ☐ |
| L. Other resources which can be quickly changed into cash (specify)________ | ☐ | ☐ |

| Type of Resource | Owner | Current Value | Name and Address of Banks, etc. | Account Number |
|---|---|---|---|---|
| | | $ | | |
| | | $ | | |
| | | $ | | |

16. Do you or any family member have life insurance? Yes ☐ No ☐ If yes, list:

| Insurance Company | 1. Person Insured / 2. Policy Owned by | Face Value of Insurance | Policy Number | Date Policy Issued | Current Cash Value |
|---|---|---|---|---|---|
| A. | 1. ________ 2. | $ | | | $ |
| B. | 1. ________ 2. | | | | |
| C. | 1. ________ 2. | $ | | | $ |

17. Do you or any family member own a burial reserve or trust? Yes ☐ No ☐

If yes, purchase price $________ Amount owed $________

$________ $________

For whom purchased________

From whom purchased________

18. Do you or any family member own a burial plot, vault, or crypt? Yes ☐ No ☐

For use of immediate family? Yes ☐ No ☐

If for use of anyone other than a member of the immediate family, complete the following:

Description________ Owned by________

Estimated value $________ Amount owed $________

Location________

19. Do you or any family member own items of jewelry valued at more than $100 each? (Do not include wedding and engagement rings or heirlooms.) Yes ☐ No ☐ If yes, list:

| Description | Estimated Value | Amount Owed |
|---|---|---|
| A. | $ | $ |
| B. | $ | $ |

COUNTY USE ONLY

For A, B, C, D, and/or E Income in the month included? Yes ☐ No ☐ If yes amount:

$________

For A, B, and/or C Income from business or self-employment included? Yes ☐ No ☐ If yes amount:

$________

(See 26C)

Date Verified ________ EW ________

Total CSV $________

Date Verified ________ EW ________

Current value

$________

Date Verified ________ EW ________

Heirlooms?

Appraised value

$________

or poultry not for personal use)? Yes ☐ No ☐ If yes, list:

| Description | Estimated Value | Amount Owed |
|---|---|---|
| A. | $ | $ |
| B. | $ | $ |
| C. | $ | $ |

21. Have you or any family member transferred, sold, or given away any property (including money) at any time since you first applied for Medi-Cal or during the two years prior to that? Yes ☐ No ☐ If yes, list:

| Description of Item | Date of Transfer, Sale, or Gift | Value | Amount Received |
|---|---|---|---|
| A. | | $ | $ |
| B. | | $ | $ |

22. Do you or any family member have any of the following sources of income? Check yes or no for each item. If yes, explain below. Include loans, date loan received, and whether or not loan is repayable in "Other."

A. TYPE OF INCOME

| | Yes | No |
|---|---|---|
| Cash grant (welfare), e.g., SSI/SSP (gold check), AFDC, GR, or GA | ☐ | ☐ |
| Social Security: i.e., Retirement, Survivors, Disability | ☐ | ☐ |
| Railroad Retirement | ☐ | ☐ |
| Nonmilitary retirement or pension | ☐ | ☐ |
| Unemployment Insurance Benefits (UIB) | ☐ | ☐ |
| bility insurance: check one: state ☐ private | ☐ | ☐ |
| Workers' Compensation | ☐ | ☐ |
| Veteran's benefits including GI Bill | ☐ | ☐ |
| Military retirement | ☐ | ☐ |
| Military allotment | ☐ | ☐ |
| Child support | ☐ | ☐ |
| Alimony | ☐ | ☐ |
| Payment from roomers | ☐ | ☐ |
| Monetary gifts/contributions | ☐ | ☐ |
| Interest income and dividends | ☐ | ☐ |
| Other (itemize) | ☐ | ☐ |

| B. Name of Person Receiving Income | Type of Income | Date Received (or Expected) | Amount | How Often? (Weekly, Monthly) |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

C. Do you receive or expect to receive a cost-of-living increase to this income one or more times a year? Yes ☐ No ☐ If yes, give date of last and next cost-of-living increase.
Last ____________ Next ____________

23. Do you or any family member receive any of the following items free or in exchange for work you do?

| | | | | |
|---|---|---|---|---|
| A. Rent or housing | Yes ☐ | No ☐ | Who receives: | From whom: |
| B. Food | Yes ☐ | No ☐ | Who receives: | From whom: |
| C. Utilities | Yes ☐ | No ☐ | Who receives: | From whom: |
| D. Clothing | Yes ☐ | No ☐ | Who receives: | From whom: |

24. Do you or any family member pay child support or alimony under a court order or based on an agreement with the district attorney? Yes ☐ No ☐ If yes, complete the following:

| Amount Paid | By Whom | To Whom |
|---|---|---|
| | | |
| | | |

COUNTY USE ONLY

Disposition of proceeds:

Note: Refer to transfer of property regs. in Title 22.

Type of cash grant:

Verification (list):

Date Verified EW

Verification (list):

Date Verified EW

Yes ☐ No ☐ If yes, complete the following:

| | | | | COUNTY USE ONLY |
|---|---|---|---|---|
| A. 1. Working member's name | | | | Verification (list) |
| 2. Employer's name | | | | ☐ Wage stubs |
| 3. Address of employer | | | | |
| 4. Days of work per week | Days | Days | Days | |
| 5. Hours of work per week | Hrs. | Hrs. | Hrs. | |
| 6. How often paid (every week, twice a month, every two weeks, etc.) | | | | |
| 7. Day of the week you are paid | | | | |
| 8. Gross (total) earnings per pay period (before deductions) (include tips). If self-employed, write self-employed here and complete No. 26. | $ | $ | $ | ☐ Tips |
| 9. Occupation | | | | |

B. 1. Do you pay child care necessary for work? Yes ☐ No ☐ $______ monthly amount

2. Do you pay for the care of an incapacitated adult living in your home in order to be able to work? Yes ☐ No ☐ $______ monthly amount Name ______ Relationship ______

Verification of dependent care

Date Verified EW

C. Anticipated Income. If your income varies from month to month, show your actual gross income for the current month in Month 1 and your estimated gross income for the following two months in Month 2 and Month 3.

| Name and Occupation | Month 1 | Month 2 | Month 3 |
|---|---|---|---|
| | $ | $ | $ |
| | $ | $ | $ |
| | $ | $ | $ |

D. Additional Information. Explain reasons for entries in C. Also, state any facts concerning your employment which may affect future months (for example, temporary employment).

26. Are you or any family member self-employed? Yes ☐ No ☐ If yes, complete the following. If no, proceed to question 27.

Verification
☐ Tax return
☐ Business records

A. Name of business ______

Type of business ______

Location ______

Date Verified EW

| B. Adjusted Gross Income From Last Tax Statement | Has Income Changed Since Last Tax Statement: Yes | Has Income Changed Since Last Tax Statement: No | If No Tax Statement or Change in Income: Estimated Yearly Gross Profit | If No Tax Statement or Change in Income: Estimated Yearly Business Expenses |
|---|---|---|---|---|
| $ | | | $ | $ |

Net profit from self-employment: $

| C. Cash on Hand for Business | Money in Checking Accounts for Business | Average Monthly Cash Expenditures for Business |
|---|---|---|
| $ | $ | $ |

... IF THE FAMILY INCLUDES CHILDREN UNDER 21.

Is a parent living in the home unemployed or working less than 100 hours per month? If yes, COMPLETE THE FOLLOWING FOR THE CHILD(REN)'S PARENT(S) WHO IS/ARE LIVING IN THE HOME:

A. FIRST PARENT (name ________________________). List employment and training history for the past five years. Begin with this person's last job or training.

| Name of Employer or Training Program | Work or Training ✓ Check | When Employed From / / mo dy yr To / / | Amount Paid | Name of Employer or Training Program | Work or Training ✓ Check | When Employed From / / mo dy yr To / / | Amount Paid |
|---|---|---|---|---|---|---|---|
| 1. | ☐ Work ☐ Training | From / / To / / | $ ☐ Weekly ☐ Monthly | 7. | ☐ Work ☐ Training | From / / To / / | $ ☐ Weekly ☐ Monthly |
| 2. | ☐ Work ☐ Training | From / / To / / | $ ☐ Weekly ☐ Monthly | 8. | ☐ Work ☐ Training | From / / To / / | $ ☐ Weekly ☐ Monthly |
| 3. | ☐ Work ☐ Training | From / / To / / | $ ☐ Weekly ☐ Monthly | 9. | ☐ Work ☐ Training | From / / To / / | $ ☐ Weekly ☐ Monthly |
| 4. | ☐ Work ☐ Training | From / / To / / | $ ☐ Weekly ☐ Monthly | 10. | ☐ Work ☐ Training | From / / To / / | $ ☐ Weekly ☐ Monthly |
| 5. | ☐ Work ☐ Training | From / / To / / | $ ☐ Weekly ☐ Monthly | 11. | ☐ Work ☐ Training | From / / To / / | $ ☐ Weekly ☐ Monthly |
| 6. | ☐ Work ☐ Training | From / / To / / | $ ☐ Weekly ☐ Monthly | 12. | ☐ Work ☐ Training | From / / To / / | $ ☐ Weekly ☐ Monthly |

B. SECOND PARENT OR OTHER SPOUSE for whom aid is requested (name ________________________). List employment and training history for the past five years. Begin with this person's last job or training.

| Name of Employer Training Program | Work or Training ✓ Check | When Employed From / / mo dy yr To / / | Amount Paid | Name of Employer or Training Program | Work or Training ✓ Check | When Employed From / / mo dy yr To / / | Amount Paid |
|---|---|---|---|---|---|---|---|
| 1. | ☐ Work ☐ Training | From / / To / / | $ ☐ Weekly ☐ Monthly | 7. | ☐ Work ☐ Training | From / / To / / | $ ☐ Weekly ☐ Monthly |
| 2. | ☐ Work ☐ Training | From / / To / / | $ ☐ Weekly ☐ Monthly | 8. | ☐ Work ☐ Training | From / / To / / | $ ☐ Weekly ☐ Monthly |
| 3. | ☐ Work ☐ Training | From / / To / / | $ ☐ Weekly ☐ Monthly | 9. | ☐ Work ☐ Training | From / / To / / | $ ☐ Weekly ☐ Monthly |
| 4. | ☐ Work ☐ Training | From / / To / / | $ ☐ Weekly ☐ Monthly | 10. | ☐ Work ☐ Training | From / / To / / | $ ☐ Weekly ☐ Monthly |
| 5. | ☐ Work ☐ Training | From / / To / / | $ ☐ Weekly ☐ Monthly | 11. | ☐ Work ☐ Training | From / / To / / | $ ☐ Weekly ☐ Monthly |
| 6. | ☐ Work ☐ Training | From / / To / / | $ ☐ Weekly ☐ Monthly | 12. | ☐ Work ☐ Training | From / / To / / | $ ☐ Weekly ☐ Monthly |

C. HAS EITHER PERSON LISTED IN 27A OR B RECEIVED UNEMPLOYMENT INSURANCE BENEFITS (UIB) WITHIN THE LAST 12 MONTHS? Yes ☐ No ☐ If YES, complete:

| Name of Person | Dates Received |
|---|---|
| | |
| 2. | |

COUNTY USE ONLY

First Parent's Earnings

| YR. | QUARTER Jan-Mar | Apr-Jun | Jul-Sept | Oct-Dec |
|---|---|---|---|---|
| | EARNINGS | | | |
| | $ | | | |
| | $ | | | |
| | $ | | | |

Total Earnings $________

| YR. | QUARTER Jan-Mar | | Apr-Jun | | Jul-Sept | | Oct-Dec | |
|---|---|---|---|---|---|---|---|---|
| | $50 | Trng. | $50 | Trng. | $50 | Trng. | $50 | Trng. |
| | | | | | | | | |

☐ Quarters________

Second Parent's Earnings

| YR. | QUARTER Jan-Mar | Apr-Jun | Jul-Sept | Oct-Dec |
|---|---|---|---|---|
| | EARNINGS | | | |
| | $ | | | |
| | $ | | | |
| | $ | | | |

Total Earnings $________

Primary Wage Earner
☐ 1st ☐ 2nd Parent

| YR. | QUARTER Jan-Mar | | Apr-Jun | | Jul-Sept | | Oct-Dec | |
|---|---|---|---|---|---|---|---|---|
| | $50 | Trng. | $50 | Trng. | $50 | Trng. | $50 | Trng. |
| | | | | | | | | |

☐ Quarters________

UIB:
☐ Eligible ☐ Referral
☐ Eligible ☐ Referral

28A. Have either of the child(ren)'s parents living in the home quit or refused a job or training within the last 30 days? If yes, complete below. Yes ☐ No ☐

| Parent's Name | Amount of last paycheck | Last day of job/training mo. day yr. | Hours of work/training in last 30 days |
|---|---|---|---|
| | $ | / / | |

| Name and Address of Employer/Training Program | Reason for Leaving or Refusal |
|---|---|
| | |

B. Are you or anyone in your family participating in a labor strike? Yes ☐ No ☐ If yes, complete.

| Who | Date Person Went on Strike |
|---|---|
| | |

29. Are you or any family member in college or attending a similar educational institution? Yes ☐ No ☐
If yes, complete the following: Full-Time ☐ Part-Time ☐

| | Student: | Student: | Student: |
|---|---|---|---|
| A. 1. Name of institution | | | |
| 2. Status of student | Grad ☐ Undergrad ☐ | Grad ☐ Undergrad ☐ | Grad ☐ Undergrad ☐ |
| B. Grants, loans, scholarships, fellowships | | | |
| 1. Amount received | $ | $ | $ |
| 2. Source(s) of grants, loans, etc. | | | |
| 3. How often received | | | |
| C. Expenses Per Term | | | |
| 1. Is term a semester, quarter, year | | | |
| 2. Tuition/fees | $ | $ | $ |
| 3. Books, equipment, and supplies | $ | $ | $ |
| 4. Child care necessary for school | $ | $ | $ |
| 5. Transportation to school—child care | | | |
| a. Round trip miles per day | | | |
| b. School attended how many days per week | | | |
| c. Type of transportation used (own car, someone else's car, car pool, bus, etc.) | | | |
| d. Costs (per month) • Amount paid by student (if doesn't use own car) | $ | $ | $ |
| • Amount paid by riders | $ | $ | $ |
| e. Parking, tolls, etc. | | | |
| f. Is public transportation (bus, train, etc.) available | Yes ☐ No ☐ Cost $ | Yes ☐ No ☐ Cost $ | Yes ☐ No ☐ Cost $ |

30. Do you or any family member have Medicare coverage? Yes ☐ No ☐ If yes, list:

| Person Covered | Medicare Claim Number | Monthly Premium: Deduction From Check | Monthly Premium: Paid by You |
|---|---|---|---|
| A. | | Yes ☐ No ☐ | Yes ☐ No ☐ |
| B. | | Yes ☐ No ☐ | Yes ☐ No ☐ |
| C. | | Yes ☐ No ☐ | Yes ☐ No ☐ |

COUNTY USE ONLY

☐ Employer statements

☐ Determination of "good cause" required

☐ Striker(s)

Verification (list):

Date Verified EW

Exempt:
☐ Entire amount
☐ Only expenses

Transportation costs allowed: (show computation)

Date Verified EW

31. Do you or any family member have health or hospitalization insurance, including insurance paid by an employer or absent parent? This information will not affect your eligibility for Medi-Cal.
Yes ☐ No ☐ If yes, complete the following:

| Coverage (Check) | Person(s) Insured | Monthly Premium Paid |
|---|---|---|
| ☐ CHAMPUS/CHAMPVA | | $ |
| ☐ Veterans Administration coverage (50% or above disability rating) | | $ |
| ☐ Kaiser | | $ |
| ☐ Ross-Loos (INA) | | $ |
| ☐ Blue Shield | | $ |
| ☐ Blue Cross | | $ |
| ☐ Other | | $ |

32. Have you or any family member made a down payment for medical care you will receive in the future?
Yes ☐ No ☐ If yes,

| Amount of Down Payment | To Whom Made | Medical Care to be Received |
|---|---|---|
| $ | | |

33A. Have you or any family member ever been in U. S. military service? Yes ☐ No ☐

B. Are you or any family member the spouse, parent, or child of a person who has been in U. S. military service? Yes ☐ No ☐

34. Have you or any family member applied for or do you or any family member think you are eligible for any payment/s you are not now receiving? Yes ☐ No ☐ If yes, complete the following:

| Kind of Payment | Person Possibly Eligible | Date of Application Month/Day/Year | Date Expected Month/Day/Year |
|---|---|---|---|
| Social Security | | | |
| ability payments | | | |
| veteran's payments | | | |
| Unemployment Benefits | | | |
| Workers' Compensation | | | |
| Medicare | | | |
| Pending suit or insurance settlement for accident or injury | | | |
| Other: Describe | | | |

35. Services (these questions do not affect your eligibility for Medi-Cal)

A. Are you interested in physical examinations for any family member under 21 through the Child Health Disability Prevention Program? Yes ☐ No ☐

B. Are you interested in information on the Family Planning Program? Yes ☐ No ☐

C. Are you interested in talking to a social services worker about other services which may be available to you? Yes ☐ No ☐ If yes, explain:

36. Additional information. Please give the item number in the column to the left.

| | |
|---|---|
| | |
| | |
| | |
| | |

COUNTY USE ONLY

Date HRB 2 completed

☐ Other health coverage code entered

Verification (list)

Date Verified EW

Payment used to brin property within propert limits Yes ☐ No ☐

If yes:
☐ Notice to provider

CA 5 ☐

CA 5 ☐

Date Verified EW

Medi-Cal recovery referral

Date

Date of accident/injury

Medi-Cal recovery referral

Date

☐ CHDP brochure given

Date

☐ CHDP referral

☐ Social services referral

BE SURE YOU HAVE READ EVERY ITEM AND ANSWERED ALL THE QUESTIONS.
READ THE FOLLOWING CAREFULLY BEFORE SIGNING.

- I agree to tell the county welfare department within TEN DAYS if there are any changes in my (or the person's on whose behalf I am acting) income, possessions, or expenses or in the number of persons in the household or of any change of address or of any change in other health insurance coverage; and I agree to meet all other responsibilities explained in the "Medi-Cal Responsibilities Checklist" I have received.

- I understand that I must report immediately the death of a member of my household or the person on whose behalf I am acting.

- I understand that the information I put on this form will be verified and that I must cooperate fully in any investigation required for quality control.

- I understand that Section 700.1 of the Probate Code and Section 14009.5 of the Welfare and Institutions Code provide for the recovery of all Medi-Cal benefits received after age 65 from the estate of a Medi-Cal beneficiary if there is no surviving spouse, minor children, or blind or totally disabled children.

- I understand that any information gathered is confidential and not open to inspection other than for purposes directly connected with the administration of the Medi-Cal program.

- I understand that if I am dissatisfied with actions taken by the county welfare department, I have the right to a state hearing.

IF YOU DO NOT UNDERSTAND THESE STATEMENTS OR IF YOU HAVE ANY QUESTIONS, ASK YOUR COUNTY WORKER TO EXPLAIN.

I REALIZE THAT IF I DELIBERATELY MAKE FALSE STATEMENTS OR WITHHOLD INFORMATION, I (OR THE PERSON ON WHOSE BEHALF I AM ACTING) MAY LOSE MY MEDI-CAL CARD AND/OR I CAN BE PROSECUTED FOR FRAUD.

I DECLARE UNDER PENALTY OF PERJURY THAT THE ANSWERS I HAVE GIVEN ARE CORRECT AND TRUE TO THE BEST OF MY KNOWLEDGE.

| Signature of Applicant | | Date |
|---|---|---|
| Signature of Person Acting for Applicant | Relationship | Date |
| Signature of Witness (If Applicant Signed With Mark) | | Date |
| Signature of Person Helping Applicant Complete Form | Address | Date |

| COUNTY USE ONLY | |
|---|---|
| | EW Signature |
| | Date |
| | |

## Revised Statement of Facts for Medi-Cal
## Description of Changes

The format of the MC 210 has not been changed. In sequence, the format is: 1) personal identification and program identification; 2) resource identification; 3) income identification; 4) linkage to AFDC; 5) other health coverage; 6) potentially available assistance.

Please note that in the numbering sequence, questions 1 through 22 remain unchanged. However, questions 23 through 35 are rearranged as follows:

| Current | Revised | Current | Revised | Current | Revised |
|---|---|---|---|---|---|
| 23 | 25 | 27 | 24 | 32 | 34 |
| 24 | 26 | 28 | 31 | 33 | 27, 28 |
| 25 | 23 | 29 | 30 | 34 | 35 |
| 26 | 29 | 30 | 32 | 35 | 36 |
| | | 31 | 33 | | |

Page 1

County Use Column

-- Added verification of identity. Title 22 CAC 50167 (a)(6) requires verification of the identity of at least one parent or adult member of the case. Case review indicates that many eligibility workers (EWs) either fail to verify identity or fail to document such verification.

Page 2

Question 6

-- Reworded this question. The current MC 210 asks if all applicants are citizens. The actual intent is to question alien status. This revision, which is adapted from the AFDC Statement of Facts Supporting Eligibility for Assistance (CA 2), clearly identifies that the question concerns alien status.

Question 7

-- Redrafted this question to identify specific aid programs. The current MC 210 is inadequate for identifying potential Title II Disregard status.

County Use Column

-- Removed reference to property spenddown.

Question 9

-- Added new item c. This question is intended to specifically question applicants claiming disability as to whether a lawsuit/insurance settlement is pending. Quality Control (QC) reviewers have identified cases in which applicants have failed to disclose pending lawsuits. This question should increase identification of potential third party liability.

County Use Column

-- Added referral to Medi-Cal Recovery to Question 9C. to remind EWs of this requirement.

Page 3

Question 10

-- Added "monthly payment" to question regarding amount of mortgage payment. This allows comparison of monthly income to monthly expenses and can help identify discrepancies.

County Use Column

-- Added verification statements for Questions 11, 13 and 14. Title 22, CAC, 50167 requires that EWs verify the information contained in these questions. Some EWs fail to document such verification.

Page 4

Question 15

-- Revised this question in order to save space. This format is used in the CA 2 and is slightly more detailed.

County Use Column

-- Added verification statements for questions 15, 16, 17 and 19. Inappropriate treatment of these resources has caused QC errors. Some EWs fail to document verification, fail to update CSV of insurance or value of a burial reserve or trust after the initial application. In addition, verification of this information is required by 22 CAC 50167.

Page 5

Question 22

-- Rearranged this question in order to save space.

-- Added military retirement since it is not clearly identified on the current form.

-- Added sub-item C, based upon a recommendation by Quality Control and Evaluation Branch.

Question 23. (formerly question 25)

-- Moved this question in order to conserve space.

Question 24. (formerly question 27)

-- Moved this question in order to conserve space.

Page 6

County Use Column

-- Added verification instructions to questions 25 and 26 (formerly questions 23 and 24) because EWs very seldom list the type of verification provided. In addition, some EWs neglect to verify the cost of dependent care.

Page 7

Question 27 (formerly part of question 33)

-- Revised completely the question on unemployed parent(s). The current MC 210 does not contain any questions about primary wage earner. In addition, current question 33 is inadequate for identifying connection to the labor force. These two factors are a main requirement for linkage to AFDC based on an unemployed parent (22 CAC 50215 (b) and (c)). QC reviews indicate deprivation errors cause between 10 and 20 percent of the State's erroneously paid Medi-Cal dollars. Therefore, this question must be clarified.

The format for this question was adopted from AFDC's CA 2.

Page 8

Question 28 (formerly part of question 33)

-- Revised question and moved from question 33. This question also was adopted from the CA 2. Federal and State law and regulation prohibit AFDC/MN linked Medicaid/Medi-Cal coverage for persons refusing a job without good cause or for participating in a strike. (See also 22 CAC 50215 (b) and (c)).

Question 29. (formerly question 26)

No change.

Question 30. (formerly question 29)

No change.

Page 9.

Question 31. (formerly question 28)

-- Revised this question in conformity with Recovery Branch input.

County Use Column

-- Added check for coding other health coverage.

-- Added verification requirement. Title 22, CAC, Section 50167 (a)(7)(T) requires verification of available health care benefits. EWs do not always obtain the type of verification required.

-- Added referral for Medi-Cal Recovery to question 34 (formerly question 32). Title 22, CAC, Section 50771 requires county departments to notify the State of potential third party payments (TPL). The additions to the verification requirements in question 34 should remind EWs of this requirement.

Page 10. Informational Statements

-- Moved penalty of perjury statement to immediately above signature block.

-- Added phrase on other health coverage to reporting responsibilities statement.

-- Added statement on reporting death of a beneficiary.

-- Revised statement on verification of information and QC investigations.

-- Added "blind" child to statement on recovery from the estate of a decedent beneficiary.

-- Revised and limited statement on confidentiality.